STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555684	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Post Acute Care	1790 Muir Road Martinez, CA 94553

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to ensure timely reporting of an abuse allegation incident, to the California Department of Public Health (CDPH), for one of four sampled residents (Resident 1). This failure interfered with the timely investigation of abuse allegation and had the potential to prevent further abuse.The alleged abuse incident occurred on 2/25/26 at around 6 a.m. and the facility reported the incident to CDPH on 2/26/26 at 8:40 a.m.Findings:During a review of the facility's abuse incident fax report, dated 2/26/26, the fax report indicated that a report to CDPH was faxed on 2/26/26 at 8:40 a.m. regarding an alleged abuse incident involving Resident 1. During a review of Resident 1's face sheet, dated 4/3/26, the face sheet indicated Resident 1 has stage 4 kidney disease (severe kidney failure), anxiety, and dementia (a decline in mental ability severe enough to interfere with daily life, caused by physical changes in the brain).During an interview on 4/2/26 at 11:35 a.m., with Director of Nursing (DON), DON stated the alleged abuse on Resident 1, occurred the morning of 2/25/26 at around 6 a.m. and it wasn't until the next day, on 2/26/26, that the facility's Director of Staff Development [DSD] was made aware of the alleged incident.During interview on 4/2/26 at 12:26 p.m., with Certified Nursing Assistant (CNA)1, CNA 1 stated that she witnessed CNA 3 pull Resident's 1 hair during activities of daily living (ADL) care (self-care tasks such as bathing, dressing, getting out of bed and toileting) on 2/25/26. CNA 1 stated she told CNA 2 about the incident the next day, 2/26/26. CNA 1 stated she told CNA 2 that she had 24 hours to report the incident.During an interview on 4/2/26 at 1:50 p.m., with Director of Staff Development (DSD), DSD stated that she received a call on 2/26/26, from CNA 2 stating that CNA 1 had told her that she saw CNA 3 pull patient's hair during the morning of 2/25/26. DSD stated that on the morning of 2/26/26, she then called CNA 1 to write a statement of the incident. DSD stated that the alleged abuse reporting should have been reported immediately, and that the alleged abuse incident reporting was delayed, and did not meet the facility's abuse training and policy expectations.During an interview on 4/3/26 at 1:33 p.m., with CNA 2, CNA 2 stated that CNA 1 had mentioned to her that she witnessed CNA 3 pull Resident 1's hair but CNA 1 had not reported the incident. CNA 2 stated she told CNA 1 that she had to report the incident immediately. CNA 2 stated she notified the facility's DSD in the early morning of 2/26/27 of the alleged abuse incident. CNA 2 stated that alleged abuse reporting needs to happen immediately, and failure to report could put residents and the staff at risk of harm.During an interview on 4/3/26 at 2:26 p.m., with the Director of Nursing (DON), DON stated that CNA 1 did not report the abuse allegation to her directly. DON stated that DSD had called CNA 1 the day following the alleged incident [on 2/26/26] and DSD requested CNA 1's written report of the incident. DON stated that it was unacceptable to delay any abuse reporting, and the delayed reporting (of Resident 1's alleged incident) did not meet her expectations.During a review of the facility's policy and procedure (P&P) titled, Abuse Investigation and Reporting, revision dated 12/2016, the P&P indicated, All reports of resident abuse. shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management.During a review of the facility's policy and procedure (P&P) titled, Alleged or Suspected Abuse and Crime Reporting, dated 11/2016, the P&P indicated, It is the responsibility of all employees to immediately (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	report to facility administrator, and to other officials in accordance with Federal and State law, any incident of suspected or alleged abuse.All reports shall be timely and thoroughly investigated.